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SOME REMARKS ON CATARACT.

By EDWARD G. LORING, M.D., New York. Read before the American Ophthalmological Society, July, 1871.

MR. PRESIDENT.—As you are well aware, it has long been recognized that astigmatism often occurs as a disturbing element in the vision of patients who have been operated upon for cataract. Thus Dr. Knapp, in Graefe's Archives for 1867, observes that "we should not neglect to test eyes which have been operated on for cataract, with cylindrical glasses, to see if vision is not thereby improved. This is found to be the case in a marked degree, where the result has been a good one, in about one-fourth of the cases. Thus I have found where $V = \frac{1}{4}$, corrected it will be $\frac{1}{2}$, and $V \frac{1}{2}$ will become $\frac{2}{3}$ and so on."

But notwithstanding this knowledge of its existence, very little has been done by the majority of operators in determining the degree of this error in refraction when making out their statistics of vision, and still less has the attempt been made to remedy the defect by prescribing suitable glasses.

This latter is no doubt due to the fact that the necessary spherocylindric glass is so heavy and of so awkward a shape as only to be worn with great discomfort to the patient. Thus if we wished to give a spherical glass, for example $+\frac{1}{4}$ combined with a cylindric glass, the spherical surface inasmuch as it would have to be put all on one side would have to be ground on a radius of 2 inches. This degree of curvature would, in order to fill the eye of the spectacle frame, require the glass to be very thick in the centre, the apex of which would consequently project a good deal from the plane of the rim of the spectacle, while the slight curvature of the cylindric surface would hardly project at all. Such a glass as this is necessarily very heavy, and very clumsy and uncomfortable.

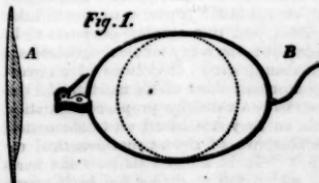
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With the hope of remedying these objections so as to allow us to give astigmatic glasses to cataract patients, I have contrived the glass which I now present to the Society, and which is made in the following manner:—

A simple cylindric glass of the required strength is first set in the spectacle frame in the usual way, the axis of the glass of course running in the required direction. A thin plano-convex glass is then ground, and, taking advantage of the fact that lenses can be cemented together by Canada balsam, this is firmly fixed by its plane surface to the back or plane surface of the cylindric glass.

As the diameter of the plano-convex is made only equal to the vertical diameter of the spectacle frame, and not to the longitudinal one, it follows that a large quantity of glass is thus dispensed with, and the weight of the glass is thereby much reduced—the two combined lenses being, in fact, when nicely made, only one-fourth of the weight of the common spherical cataract glass as found in the shops.

In the figure, *A* gives a longitudinal section of the glass, the dotted line making the line of union between the two lenses, while *B* shows the front view of the glass as it appears in the frame, the dotted line showing the circumference of the plano-convex glass.



As you will observe, the edge of the convex lens is so delicately ground and so perfectly fitted to the cylindric glass, that the point of union is barely perceptible when the glass is worn, and the peculiarity of its [WHOLE NO. 2280]

construction would escape the notice of any but a very observant eye.

The pair which I now offer as a sample has a spherical surface of $+\frac{1}{4}$ (really equal to a biconvex $+\frac{1}{4}$) and a cylindric surface $+\frac{1}{2} c$, the patient being astigmatic to that degree in the vertical meridian. With the best corrective with spherical glasses vision equalled $\frac{1}{2}$. With this glass it rose to $\frac{1}{4}$.

The chief objection which would be raised against glasses made in this manner would, in all probability, be on account of their liability to come apart. Whether this is a valid objection remains to be proved. I would say that this pair has been in constant use for four months, and in that time they have been dropped twice, once in a crowd, from which they were only rescued after the frames had been considerably bent. They certainly show no signs of separation between the two lenses, and we know that the lenses of telescopes and opera glasses are subjected, oftentimes for years, to the extremes of temperature and hard usage without showing such a tendency; and even if the glasses should occasionally separate, it is certainly a simple matter to recement them. This slight inconvenience would be more than compensated, it seems to me, by the increased amount of vision, especially when, as in the present case, it is doubled.

In this connection I would remark that it seems to me that a want of uniformity now exists among operators in regard to testing the vision of cataract patients, which has a tendency, to say the least, to create confusion, not only as to the results of different operators, which is of comparatively small importance, but also as to the merits of the method of operating itself, which is of vast importance.

It is almost universally considered now, after the so-called peripheric linear has been in vogue for the past eight years, and after it has been consequently thoroughly tried, that it is far superior to the old flap operation, and this opinion purports to be founded not—as many medical opinions are—on unsupported convictions of its great originator and a few of his most skilful disciples, but on carefully prepared statistics, which, as they are based on mathematical principles, are of almost mathematical exactness. It is alleged that as the basis upon which the statistics for both operations were compiled was the same, namely Snellen's method, it follows that the comparison must be a just one, and as the peripheric linear yielded more favorable results this was the better operation.

From this opinion, prevalent as it is, we

demur, and believe that although the method of testing was the same, yet the standard used was different, and that consequently the conclusions drawn are not only unreliable, but even erroneous, and that, so far as statistics go, it is at least still a question whether the old flap, and not the new peripheric linear, does not give the best results.

To show that this is the case, reference must be made to the statistics themselves.

In 1863, Graefe published the results of 1500 cases of flap extraction.* Out of these he got 65 per cent. of immediate good results, with 15 per cent. additional after a secondary operation, making 80 per cent. as a grand total of perfect success. In these cases "vision of at least $\frac{1}{2}$ " is taken as the standard necessary for a good result. In patients over 75 years, however, $V = \frac{1}{2}$ is allowed. There was a total loss of 6 to 8 per cent.

In a later paper,† however, Graefe gives another series of cases in which he gets 84 per cent. of perfect results, 11 per cent. of half successes, and a total loss of 5 per cent., and he then states that in his private practice the results were even better than this, namely 91 per cent. of perfect results, 6 per cent. of half successes, and only 3 per cent. of absolute loss. 91 per cent. of patients with vision $\frac{1}{2}$ and over, and only 3 per cent. of total loss is a result which we venture to say has never been equalled by any other method.

If we now turn to the peripheric linear, we find at the outset that "Graefe," as Dr. Norris says, ‡ "has not given us so extended and full an analytical report of his cases as would be desirable," but he did publish 300 cases (Archiv xii., part 1, p. 151), in which he got 90 per cent. of perfect immediate good results. But here, instead of taking vision $\frac{1}{2}$ as a standard, he took $\frac{1}{4}$, and we have no means of knowing how many cases were included between $V = \frac{1}{2}$ and $V = \frac{1}{4}$. But if, for the sake of calculation, we take the difference between $\frac{1}{2}$ and $\frac{1}{4}$ we must then subtract 9 per cent., which would leave 81 per cent. of cases with vision $\frac{1}{2}$. Graefe then goes on to state that out of the 10 per cent. which comprises total failures and imperfect successes, enough would have been benefited by secondary operations to have given a grand total of 94 per cent. of perfect results. Admitting that this "would have been" the case, we must

* Zehnder Klin. Monatsblat, p. 146.

† Archiv für Ophth., vol. xi., part 3, p. 7, 1865.

‡ American Journal of the Medical Sciences, January, 1871, p. 243.

still take, in order to make the comparison a just one, 9 per cent. away, which would leave a grand total of 84.6 per cent. of perfect results, against 84 of the second and 91 of the third series of flap operations. Thus we see that the balance swings if anything a little in favor of the flap operation. Whether this may be accounted for in the difference between strictly private and a mixed series of patients it is hard to say. But what is plain is that, even in Graefe's hands, the results of each method are so nearly equal that it is still an open question which is the better; or, to say the least, there is no sufficient cause, so far as statistics are concerned, for the now almost universal belief that the linear is so much superior to the flap.

Were this prevalent opinion, however, founded upon Graefe's results alone, little more would need to be said, but inasmuch as it has apparently been confirmed by those of others hardly less skilful than he, it may not be without interest to look at the statistics of these operators, scanty though they be, which have gone so far to produce this general opinion.

Thus Dr. Knapp, who is an ardent supporter of the new operation, has published three series of cases, of 100 each, which are exceedingly interesting and instructive, on account of their fulness of detail in regard to the amount of vision obtained.

In his first series (Archiv xiii., vol. i., p. 120), Dr. Knapp claims 62 per cent perfect results. Here he uses, however, vision $\frac{1}{2}$ as a standard of success. If we apply that used in the flap, we find, on looking at the table, that out of the hundred cases we get only 39 perfect results against Graefe's first and worst series of flaps, which gave 65 per cent. of *immediate* perfect successes.

Dr. Knapp remarks that among these cases there is 14 per cent. of cases in which vision ranges from $\frac{1}{4}$ to $\frac{1}{5}$, and which are capable of being improved by a secondary operation. Admitting that one half are so improved thereby as to obtain vision equal to $\frac{1}{2}$, and this is a large proportion, we then get as a final result $39 + 7 = 46$ with vision $\frac{1}{2}$ and over.

In making out his second series (Archiv. xiv., vol. i., p. 316), Dr. Knapp says that "he, as Graefe and others have done," divides his cases into three classes, which with their respective numbers in each are as follows:—

Failures,	2	
Imperfect results ($V = \frac{1}{2} - \frac{1}{5}$),	12	
Perfect " ($V = \frac{1}{2} - \frac{1}{5}$),	86	

It will be seen from this that Dr. Knapp

claims 86 cases out of the hundred of immediate good results; but here another change takes place, and instead of taking $V = \frac{1}{2}$ or even $\frac{1}{3}$ as a standard, he takes $\frac{1}{5}$, and apparently on the authority of Graefe. This may be the case, but I can nowhere find it stated in Graefe's writing that he has ever used a scale of vision lower than $\frac{1}{2}$ as a perfect result, though it is undoubtedly true, as will be seen a little later, that others have done so, and it strikes me as manifestly unjust and unscientific to maintain the superiority of one operation by statistics in which the standard of excellence used is *two and one half times less than in the other*.

If we look at the table of specific results from which the above classification was made, we see that out of the hundred cases there are only forty in which the vision is $\frac{1}{2}$ and over. That is to say, only 40 per cent. of immediate successes according to the scale for the flap operation.

We also see that there are twelve imperfect results. Now supposing we admit, with Dr. Knapp, that one half of these imperfect results can be made perfect ones, and that in all these vision can be made, not, as he says, $\frac{1}{5}$, but even $\frac{1}{2}$; and supposing we add these cases to the 40 already perfect, we get as a final result $40 + 6 = 46$ cases out of the hundred with $\frac{1}{2}$ and over.

With vision $\frac{1}{5}$, Dr. Knapp makes the final result 98 successes.

In his third series Dr. Knapp has (Knapp's Archiv, v. i. p. 130)—

Failures,	8
Imperfect (S $< \frac{1}{5}$),	15
Perfect (S $> \frac{1}{5}$),	82

By looking at the table of specific results, we find 50 cases of immediate good results. $V = \frac{1}{2}$ and over. Admitting, with Dr. Knapp, that 9 out of the 15 imperfect could be made perfect, and allowing to these cases as before $V = \frac{1}{2}$, not $\frac{1}{5}$, which is all that Dr. Knapp claims, we get as a final result $50 + 9 = 59$ cases with $V = \frac{1}{2}$ and over.

Making now a comparison between the final results of Dr. Knapp's series of cases by peripheric linear and Graefe's by the flap, we have, arranged in tabular form, something like the following:—

Knapp, Linear.	Graefe, Flap.
1st series, 46	against 80
2d " 46	" 84
3d " 59	" 91

This averaged gives 35 per cent. in favor of the flap with vision $\frac{1}{2}$ taken as a standard in each case.

It may be objected that in the above calculation we have taken even a higher scale

than did Graefe himself in applying vision $\frac{1}{4}$ to all cases, inasmuch as Graefe made an exception of such as were over 75 years of age, reckoning in these cases $V \frac{1}{6}$ as a perfect result. As an offset to this, it must be remembered that we have allowed to Dr. Knapp 8 cases in the hundred with $V \frac{1}{4}$, when in the first series $V \frac{1}{6}$ and in the remaining two only $V \frac{1}{10}$ was claimed.

It might also be objected to as hardly fair to contrast any other operator, however skilful, with the great father of modern ophthalmology, and the above figures would go a good way toward making such an objection valid, especially as Graefe was working under the disadvantage of what is supposed to be an inferior operation. This impression will, however, be corrected, to a degree at least, when we call to mind that it has always been the custom, especially latterly, to look upon Graefe as a great medical philosopher rather than a skilful and delicate operator, though it would certainly strike one, judging simply from the results which he obtained, that he was, in this, as in all other clinical branches of our specialty, immensely superior to any one of this or any other generation.

Becker published (Zehender vol. v., p. 279, 1867) the statistics of 217 cases (150 operated upon by Prof. Arit) in which $V \frac{1}{6}$ was also taken as a perfect result; inasmuch, however, as no specific details are given as to vision, no satisfactory comparisons can be made from them, except that the final result obtained was only 83 per cent. with $V \frac{1}{6}$ and over.

Dr. Derby, of Boston, a warm advocate of the new operation, has given,* in an analysis of 61 cases of linear extraction, a tabular statement of the vision of 49 patients. Dr. Derby also reckons $V \frac{1}{10}$ and over as a perfect result, and sums up the cases as follows:—

Failures,	3
Partial success ($V \frac{1}{1}-\frac{1}{6}$),	6
Entire " ($V \frac{2}{3}-\frac{1}{6}$),	43

If, however, we reckon an "entire success" $\frac{1}{2}$ instead of $\frac{1}{6}$, we find by referring to the table that there are only 19 such cases instead of 49.

If of the 9 additional unrecorded cases we assume that 5 will have vision of $\frac{1}{4}$ and over, we get as a final result 24 cases of perfect result out of 61 or 39 per cent.

There are, indeed, other statistics by different operators, all of which, however, are compiled with so little exactness or founded upon such various and indefinite scales of measurement as to be of little value for the

purposes of comparison. Still, those which have been cited here are enough to show that the want of uniformity in the standard is a serious embarrassment in our making a just comparison not only between the results obtained by various operators, but even of the true merits of the two methods, and this is the object which we had in view.

And in this connection I would say that I can easily understand how the younger and rising school of ophthalmologists, after having gained their experience in the old method, with all the numerous mistakes and failures incident to beginners in this difficult and exacting technique, should now obtain, after they have become proficients, better results with the linear than they did at the outset with the flap. For it is certainly easier for a practised hand to change slightly the method of operating than for a novice to learn how to operate.

What we should like to see done would be for those who are skilled in both methods, and who have plenty of material, to try them side by side under the same influences and with the same tests. It is only in this way that the two operations can be justly compared. But if these conditions are too hard to fulfil, we might at any rate expect that the advocates of each method might at least conform to the very simple condition of using the same standard of measurement, be this what it may.

It may be said that the one originally taken by Graefe, namely $\frac{1}{4}$, is too high, and that it was probably for this reason that he himself changed it in the linear method. Admitting that this is true, and that $V \frac{1}{4}$ is nearer the mark, the question at once arises, what are we to do for the sake of study and comparison with the immense number of cases carefully recorded by Graefe and tabulated under the scale of $V = \frac{1}{4}$; cases which, from their great number and from the vast amount of instruction which they embody, form one of the most brilliant pages in the whole annals of modern ophthalmology? And if, to suit the progressive spirit of the age in its craving for "perfect results," we go successively from $\frac{1}{4}$ to $\frac{1}{2}$ and to $\frac{1}{6}$, where, may we ask, shall the end be?

I would say further, Mr. President, that these remarks are not in any way meant as a criticism on either operation. Had they been so, reference would have been made to many things which have not even been mentioned, and certainly to the change instituted by Graefe himself from a wound which was entirely in the sclera to one which is two-thirds or more in the cornea; and from the slight are latterly sanctioned.

by Graefe to a gradual increase in the curvature of the section, till, in the hands of many operators both in Europe and this country, the only appreciable difference between the new operation and the flap with a concurrent iridectomy is the difference between the old and the new knife.

The discussion of these points, as well as the final decision as to the merits of the respective operations, I feel had much better be left to those of my colleagues whose experience is richer and whose judgment is riper than my own.

THE RELATIONS BETWEEN HÆMOPTYSIS AND PULMONARY TUBERCULOSIS.

A CLINICAL LECTURE BY PROF. SKODA.

Translated from the *Annales et Bulletin de la Société de Med. de Gand*, for January, 1871.

PROF. NIEMEYER has recently assigned to hæmoptysis an importance entirely unlike that which it formerly was held to possess. He believes that tuberculosis is caused by the hæmoptysis itself, maintaining that the blood arrested in the bronchial tubes and in the air-cells after a hemorrhage gives rise to a chronic inflammation, and that on this depend the febrile state and the other symptoms of phthisis. If the blood thus retained in the minute bronchi and in the air-cells really possessed such an influence and could excite such an inflammatory state, we ought to expect that the same result would follow hemorrhages which attend cardiac disease. Now no such condition occurs in the course of that affection. Where an hæmoptysis takes place in patients whom we consider to be tuberculous and who die during the hemorrhage or soon after, we do not generally find any arrest of accumulated blood in the bronchi and air-cells; while if death occurs after a hemorrhage in diseased heart, there is found a collection of blood in the lung. The hemorrhagic infarctus very rarely presents itself after the hæmoptysis of tuberculosis, and is an exceptional occurrence in cardiac disease. But it is this very thing which would determine the conditions of a chronic inflammation! I have never seen such a result. Doubtless, if accumulated blood does remain, a moderate reaction occurs, in the course of which only the normal changes of the blood take place; that is, it coagulates, becomes encysted and forms the infarctus alluded to, but never progresses to suppuration. Such a hemorrhagic infarctus may last months and years, growing smaller and smaller, and finally disappearing altogether. The blood-globules undergo a metamorphosis

by which the black pigment is the result, or else disappear by fatty degeneration. The fluid elements, which become separated from the rest, are reabsorbed; the dark coloring-matter is left, and if the hemorrhagic infarctus continues any length of time it remains as black patches in the substance of the lungs. According to this view, then, the observations relative to the effusion of blood in the lungs in the course of disease of the heart accord so little with the theory of Professor Niemeyer, that one is forced to confess that this hypothesis is untenable.

According to the investigations which have been made in the living subject and upon the cadaver, it is very probable that the hæmoptysis which occurs in pulmonary tuberculosis before and during its development, has its seat in the mucous membrane of the bronchi, and not in the air-cells. If the blood came from the latter, it would certainly be very difficult to explain the rare occurrence of the hemorrhagic infarctus; but since it comes from the bronchial mucous lining, it is easy to see that none remains as a plug, but that it is expelled by coughing. I can state positively that in cases in which death occurs in the course of an hæmoptysis, it is the rare exception to find blood in the bronchial tubes, but that it is found rather in the larynx and the trachea; because, by the cough and the contraction of the bronchi, it is at once drawn forward and expelled.

So, too, I cannot accept the theory that the hæmoptysis may give rise to serious after-effects. Such a result can be only in cases in which the hemorrhage occurs in a lung tissue already diseased, especially in cavities from which the blood cannot be evacuated; and it is possible that the morbid properties peculiar to the cavities themselves contribute thus to develop a more active irritation. It is, moreover, to be noted that the blood is not specially irritant to the tissues; for example, a hemorrhage into the subcutaneous tissues after a blow does not produce any marked irritation, as we very well know, but it is generally quickly reabsorbed; so there is no reason for supposing that the blood is so irritant in a tuberculous patient as to favor the further development of the symptoms of the disease. Nevertheless, I attribute a great importance to hæmoptysis, but only as a symptom indicating that the disease is present, or that it is in process of development.

Another question here presents itself. When directly consequent upon an acute pneumonia, there remains some of the in-

flammatory product in the lungs, a chronic pneumonia is said to exist. This deposit differs materially from those peculiar to the disease which we call tuberculosis. The former can remain months and years without lighting up mischief, while in tuberculous disease cavities become formed with the greatest ease. I see, therefore, an important distinction between the two diseases, and it is useless to apply terms in common which may give rise to confusion.

Therefore we see that haemoptysis is not the cause of consecutive disease of the lung; on the contrary, the cause of the pulmonary disease resides elsewhere, and the hemorrhage is only a symptom of a morbid predisposition which subsequently manifests itself under the form of tuberculosis.

Haemoptysis likewise proceeds without doubt from other causes, cardiac disease for example. Moreover, certain cases of haemoptysis occur independent of disease of the heart, having no connection, indeed, with eventual pulmonary disease, cases in which the hemorrhage frequently recurs but with no serious pulmonary affection consequent. But such instances are rare, and are sometimes dependent on a tuberculous degeneration limited to a single point in the lung; which, once diseased, never returns perfectly to its normal state, and becomes the seat of hemorrhages which recur from time to time. Other cases also are observed in which the extravasation of blood proceeds solely from the capillaries or from dilated veins, among which anemias by anastomosis are found. Doubtless a metamorphosis of the pulmonary parenchyma can thus give rise to a serious attack of haemoptysis; these attacks may recur, and yet no tuberculosis ever result; when the hemorrhage ceases, the patient regains his previous health; debility may result, as in other cases of hemorrhage, but farther than this there exists no other symptom worth noting.

CASE OF CHRONIC ULCER OF THE STOMACH, RESULTING IN PERFORATION AND PERITONITIS.

Read before the Norfolk District Medical Society, July 12, 1871, by GEORGE J. ARNOLD, M.D., of Roxbury.

J. W. F., aged 61 years, married; has never been in firm health since having typhoid fever at the age of 25 years. Three and a half years ago he had what was called a bilious attack, commencing as a result of debility, which confined him to his bed for several days, and from which he slowly recovered. From this time he suffered ex-

ceedingly from pain in region of the stomach a little to the right of the median line, which has been more or less constant. For the past six months he has never, when conscious, been free from it, and at intervals of two or three weeks has been subject to attacks of much greater severity, lasting from 12 to 36 hours, requiring medical treatment. The pain has been of a dull, persistent character, without nausea or vomiting; has had dyspepsia. He had come to this city from Ashburnham, on the morning of the 21st of March, 1871, had visited the State-house and had done considerable other business during the day, in different parts of the city, and went to the theatre in the evening. The day was rainy, and he had made greater exertions than he had been accustomed to; but on returning to his friend's house at night, he declared he was not much fatigued; he slept well during the night, and expressed himself as much refreshed in the morning; no irregularity in diet was apparent. I learned after his decease that two days previous to coming to Boston he had exerted himself considerably in trying to carry a part of a barrel of apples from the cellar, and had felt a slight injury at the time, but seemed to have recovered from it entirely the day following.

At about seven o'clock on the 22d, he was seized with a severe pain in epigastrium. A homœopath was first called, the case coming to my notice at 12.45 o'clock, P.M. The pain was situated in the epigastrium, just over the pyloric orifice of the stomach, and resembled in virulence and paroxysmal character that occasioned by the passage of a gall-stone. Countenance anxious and distorted with pain; skin warm and natural; pulse 76, full and soft; tongue clear; inclination to nausea; no vomiting. Region of pain had a hard feel, and was very sensitive. Bowels soft and pliable. Administered morphine sulphatite half a grain, and in forty minutes, as there was no relief from pain, it was repeated. Applied chloroform externally, and gave twelve or fifteen drops internally, repeating it at intervals of fifteen minutes, for three or four times. (Strong mustard poultices had been previously applied, by direction of homœopath.) Half past two o'clock, P.M. Pain but slightly relieved; pulse 84; perspiring freely; twenty-five drops fluid extract opium given at three o'clock.

Six o'clock, P.M. Pain still severe, but lessened in violence, still retaining its paroxysmal character; pulse 104. The hard, boardy feel had extended over surface of the bowels as far as the umbilicus.

Great tenderness over seat of pain. Some tympanites. Twenty-five drops of fluid extract of opium was given soon after visit, on account of increase of pain.

Eight o'clock, P.M. Pain much less; pulse 144, small and weak; great tenderness over whole surface of bowels; tympanites increasing; bowels remarkably firm and unyielding to the touch. Voided urine, about three ounces, by estimation, containing large deposits of urates. Sp. gr. 1020; strongly acid.

Half past nine o'clock. Consultation with Dr. Cotting. Symptoms increasing in severity; pulse smaller and weaker. From this time he gradually sank, and died at seven o'clock A.M., of the twenty-third.

Autopsy by Dr. C. W. Swan, nine hours P.M.—Body emaciated. Rigor considerable. General acute peritonitis. Vivid injection of peritoneum; surfaces of contact of organs everywhere gently adherent; large masses of soft, yellowish, mucus-like fibrin in hypogastric region; a good deal of brown, muddy, homogeneous liquid of a brothy smell, sponged out from vicinity of stomach. On general inspection, the focus of the disease appeared to be in the region of the pyloric extremity of the stomach.

The lower portion of the stomach was contracted by simple, muscular effort, into a cylindrical tube, five inches in length, smooth and somewhat flattened externally, while within the mucous membrane was to the same extent thrown into strong longitudinal folds, excepting the lower inch and a half, where the folds were smaller and transverse.

Instead of a distinctly circular pyloric orifice, the parts were irregularly raised into short, heavy folds, projecting somewhat over the duodenum, apparently due, on examination of section, to thickening of the mucous membrane alone, which upon its submucous surface showed an opaque, yellowish white color and papillary form to a degree suggesting a possible state of glandular hypertrophy.

At the lower extremity of the stomach, a little anterior to the line of inner curvature, and almost reaching the origin of the duodenum, was a "chronic ulcer," with a smooth, hard, fibrous base half an inch in diameter, and pretty clearly defined. The general appearance of the ulcer was angular, from the irregular way in which the folds of mucous membrane encountered each other in the vicinity, but these folds were not, pathologically, part of the ulcer, however much they may have been due, as a

conservative force, to its indirect influence. Upon the outer anterior side of the base was a rounded perforation of no recent appearance, quarter of an inch in diameter. Externally this orifice was very well defined, smoothly circular, and rather thin edged, apparently from a gradual depression of the surrounding surface towards the opening. In the vicinity adhered some yellow and rather tough fibrin, older than that of the general peritonitis. It was not seen exactly by what this opening had been plugged prior to the occurrence of the acute symptoms. Its position must have been nearly in the angle formed by the left side of the gall-bladder and the adjacent hepatic surface, but it may have been closed by loose omental tissue, as there was nothing like a patch of old fibrin on either of the fixed surfaces mentioned. Upon the opposite side of the pyloric extremity was found the half-concealed base of a second, smaller and unperforated ulcer. There were no positive signs of irritation about these ulcers, but there was a slight injection of the minute vessels here, as in various other parts of the organ. Mucous membrane covered with thick tenacious mucus; healthy, excepting a few small, very superficial losses of substance in the longitudinal folds above mentioned. The upper part of the stomach was somewhat distended by gases and contained a light-yellowish-brown thin fluid, which did not immediately run from the perforation when the organ was held up to test this point. There was no cicatricial constriction of the pyloric orifice. The liquid found in the vicinity of the stomach resembled the contents, but was darker, as if stained by blood acted upon by gastric juice, and its odor was perceptibly less rank than that of the fluid collected from other parts of the abdominal cavity.

No remarkable distention of intestines. *Spleen* seven (?) inches long; not only quite large, but firm; quite distinct and rather coarse dark and mottling of surface of sections. *Liver* normal; *gall-bladder* nearly filled with bile, but still flaccid; *kidneys* rather dark, as from excess of blood, but apparently healthy. No microscopic examination. *Urinary bladder* somewhat distended.

Lungs healthy. Considerable hypostatic congestion of right lung; *left* comparatively dry. Upper lobes of both lungs dry. Slight, but not recent pleural adhesion on both sides. *Heart*: right side distended with blood; no large coagula noticed. Slight but evident hypertrophy of *left ventricle*, which was in a state of contraction.

It is thought that no mistake was made by confounding the thickening of contraction with that which is due to actual hypertrophy. The valves were, in general, a little thickened and opaque, but not, apparently, inefficient. Muscular substance firm.

POISONING BY STRAMONIUM, AND ITS TREATMENT.

By D. B. PUTNAM, M.D., Boston.

NOTicing, in a recent number of the JOURNAL, a case of Poisoning by Stramonium, reported by Dr. Stevens, of Charlestown, I will add the result of my experience on the same subject. While in practice for several years in a part of the country where stramonium (Jamestown weed) grows in great abundance as a weed, quite a number of cases of poisoning by this plant came under my treatment.

A majority of the cases were those of children who had eaten the seeds (for these, by the way, have not a very bad taste), though a few were the result of suicidal intemtions on the part of those of an adult age.

When called to a case, in an early stage of its toxic effects, I almost invariably found the patient laboring under dizziness, faintness, great distress, and a presentiment of approaching dissolution. Pupils were also found dilated, skin hot, pulse rapid and unsteady, corresponding, indeed, to the tumultuous action of the heart. At a later period, the patient would be found in a low muttering delirium, or with stertorous respiration, great heat of head, extreme dilation of pupils, and a great insensibility to light. At this stage, also, a rash, somewhat resembling urticaria, would make its appearance in proportion to intensity of toxic symptoms.

My treatment of these cases was usually commenced by an emetic, which generally dislodged a large quantity of the seeds, and then followed by small and frequently-repeated doses of tinct. opii, which never disappointed in its antidotal responses. For, soon the heart's action would show a tendency to return to its normal standard; the stertor and delirium decline; and all the other distressing symptoms subside: the rash and mydriasis acting as a rear guard in the retreat of the array of toxic symptoms. As this was several years ago, and before the antagonistic therapeutical action of opium on one side, and stramonium and belladonna, &c., on the other, was revealed by direct experiment, the use of the former as

an antidote to the latter was inferred from their opposite effects on the pupil.

Before closing, I will state that, in two cases, I have used stramonium as an antidote to poisoning by opium, and from the promptness and certainty of effect manifested in these cases, I would suggest to the profession a trial of its virtues in cases of this sort.

By this short article, I merely present a sort of resumé of my experience in reference to stramonium, believing it to be the duty of every practitioner to throw something, though it be but a mite, into the treasury of medical information.

Reports of Medical Societies.

BOSTON SOCIETY FOR MEDICAL IMPROVEMENT.
F. B. GREENOUGH, SECRETARY.

In the last published report of the Society, it should have been stated that the case reported by Dr. Swan, occurred in the practice of Dr. Arnold.

JULY 10th, 1871.—*Section of the Ulnar Nerve, after which a Felon on the little finger caused no Pain.*—Dr. PORTER exhibited the patient and reported the case.

A healthy young man, 22 years of age, 3 1-2 months ago was stabbed through the fore-arm by some sharp instrument, he does not know what. The point entered upon the inner and posterior aspect near the middle, about an inch inside the inner border of ulna, and came out on the anterior and outer surface, an inch to the radial side of median line. Following the injury there was complete loss of sensation of the parts of the hand supplied by the ulnar nerve, viz.: both sides of the little finger and the ulnar side of ring finger on the anterior and posterior aspects. It might be thought that there would be loss of sensation on the contiguous sides of the middle and ring fingers posteriorly, but the ulnar before supplying these generally receives a branch from the radial, which would account for the sensation being intact. The paralysis of all the muscles of the hand supplied by the ulnar could be easily demonstrated. First, The group of special muscles of the little finger forming the hypothenar eminence he could not contract in the slightest, the palmaris brevis could not be made to corrugate the skin on the ulnar border, as was easily done on the other hand. Second, The muscles of the thenar eminence or ball

of the thumb supplied by the ulnar are the adductor and part of the flexor brevis pollicis, only one of which, viz. the adductor, could be shown to be paralyzed, and in this way he could not carry the thumb toward the middle line of the hand, except by strongly contracting the long flexor of the thumb, and even then only partially. Third, All the interossei were paralyzed. Although he could flex and extend all the fingers with ease, he could not abduct them from, or adduct them to the middle line of the hand, this being the function of the interossei. There remain but two muscles supplied by the ulnar, the flexor carpi ulnaris and part of the flexor profundus digitorum, and these were intact, as they receive their nervous supply above the point of section. The two muscles, flexor brevis pollicis and flexor profundus digitorum, receiving a double nervous supply, would not be manifestly affected.

The most interesting fact connected with the case is, that three weeks after his injury he had a felon on the little finger of the hand affected, during the whole course of which he did not have a sensation of pain. When first seen by me, his finger was much swollen and red, and pus was discharging from the end of it where there was a small opening which he had made himself. An amount of pressure, which under other conditions would have caused intense pain, did not affect him in the least. The finger is now healed up, but the resolution of the inflammatory products is taking place very slowly, and only under constant compression by strapping. There is as yet no improvement in the paralysis either of sensation or motion.

JULY 10th.—*The preservation of Anatomical Specimens.*—Dr. Jackson showed the sternum of a new-born child, upon the outer surface of which was the muscle that has been described as the *sternalis*. It was removed several weeks ago, and, after the dissection of the muscle, had been left to dry. In that condition it had remained until the last twenty-four hours, when it was put into water, and thoroughly soaked out; and, on being shown to the Society, it had all the appearance of a perfectly fresh specimen. He also exhibited a diseased heart that had been removed some time before, and that it was desirable to show in a fresh state on account of some delicate appearances about the valves. It was hung up where there was a free circulation of fresh air, and thoroughly dried. During the last twenty-four hours it had been soaking in water, and, when exhibited,

it looked, as in the first case, like a perfectly fresh specimen. Dr. J. remarked that the appearances which he wished to show would have been greatly changed if the specimen had been put into spirit. Ice would have preserved it, if properly attended to; but, once thoroughly dried, it could probably have been preserved indefinitely, and at any time soaked out, when wanted for demonstration. Dr. J. has experimented successfully with some other specimens, and he thought that lecturers upon anatomy and some other subjects might in this way preserve many of their specimens for demonstration to a class, after they had been prepared by dissection. If one wished to show specimen to a friend or to a medical society, at any distance, it might often be sent in a dried state, and perhaps by mail, with directions.

AUG. 28th.—*Ulceration of the Mucous Membrane of the large Intestine.* Dr. Minor reported the case, and showed the specimen.

A man, 24 years old, Swede, entered Massachusetts General Hospital, Aug. 1st. In good health till July 30th, when he was suddenly attacked with pain in abdomen, and diarrhoea. The dejections were rather free, loose, with lumps of a dark green color, contained neither blood nor mucus—from three to eight or ten daily. No typhoid symptoms, and temperature normal. Aug. 11th, an erythematous eruption appeared over the whole body, lasting several days, and was followed by an extraordinary exfoliation of the cuticle. He gradually sank, and died Aug. 25th.

At the autopsy no disease was found except in the large intestine, the mucous membrane of which was of a slate color, and detached in numerous patches, varying in size from a line to more than an inch in diameter. It was an interesting fact that there had been no hemorrhage.

THE RHODE ISLAND MEDICAL SOCIETY.

The quarterly meeting of this Society was held at the Franklin Society Room on North Main street, Wednesday, September 20th, the President, Dr. G. L. Collins, of Providence, in the chair.

Dr. Harris reported the case of the man injured recently by a bar of iron falling upon the collar bone, producing a compound fracture of the ribs down as low as the seventh, and laying the lungs and heart bare, without injuring the pericardium. The patient was then quite comfortable, but was considered in a critical condition.

Dr. Caswell read a lengthy paper on vaccination. He commenced by tracing the history of smallpox, which is known to have existed at least nine hundred years before Christ.

Following this was an account of inoculation of smallpox, as introduced on the continent in the fifteenth century, and how the practice was prohibited by the French soon after its introduction into that country, their reason for this step being that it was the cause of spreading smallpox itself. It was not until 1796, however, that the true and safe practice of vaccination was discovered, and the fact established by Dr. Jenner that the matter from the cow infected with a disease similar to smallpox, would, when introduced into the system, produce a malady in the human species which would protect the patient from smallpox.

The Doctor then considered the question, "Is vaccination really a protection against this malignant disease?" and arrived at the conclusion that it was. He gave many statistics substantiating his position, and proved conclusively that vaccination was the only practice to adopt to insure safety to the community at large. In England, since vaccination has been practised, there are eighteen diseases known by statistics to be more destructive to human life than smallpox. He thought it the duty of States to legislate upon this matter of vaccination and make it compulsory at certain ages. The paper occupied an hour in its perusal, and was an able and instructive contribution, eliciting the closest attention from the many auditors there assembled. Dr. Snow, the acknowledged authority upon these matters in this vicinity, was called upon for a few remarks. He agreed with what had been laid down in the paper, and gave one or two cases illustrating several statements made by Dr. Caswell. He was not in favor of renewing the virus from the cow, and stated that the vaccine matter employed in this city had been through many hundred patients, and may have come, for aught he knew, from the stock obtained by Dr. Jenner. For vaccination he preferred the virus fresh from the arm, though generally he used the scab, as the former was hard to obtain. In the majority of cases he thinks that one inoculation is sufficient for life, and revaccination only necessary to prevent the varioloid. In all his experience he had never seen a perfect vaccination produced the second time on the same person. When asked at what time he considered the disease contagious, he

replied that it would be given from the first stages of the fever to the termination of the disease; but was more especially contagious when the pustules are full and dried up. It was also given by the scabs and fine powder coming from them, and particularly in the last stages, by the odor of the room or breath of the patient. As to carrying it in the clothes, he thinks there is no fear of so doing prior to the drying up of the pustules. After this time he takes precaution when visiting patients. It is seldom conveyed in the clothes of a person who is over a patient a few minutes only. When contracted in private houses, it was generally those where there was improper ventilation and but few disinfectants employed.

At the conclusion of Dr. Snow's remarks, a lively discussion ensued upon this subject, participated in by Drs. Whitney, O'Leary, Pierce, Browning, Collins, Gardner and others.

When the discussion was terminated, Dr. Capron reported the case of a lady from whom a fibrous tumor had been removed. He brought the tumor as a specimen, and gave a somewhat long and minute account of the case.

At this juncture a recess was taken, during which all present, upon invitation of the President, partook of a bountiful and sumptuous repast served in an adjoining room.

After the recess, the subject brought before the meeting by Dr. Capron was resumed, Dr. Caswell citing a case similar to that just reported. The successive steps in the operation were carefully detailed by Dr. Caswell.

Dr. Perry reported a case of extra-uterine pregnancy. Dr. Whitney mentioned several similar cases.

Dr. Collins reported the removal of a tape worm and exhibited the specimen, which was 26 feet long. It was expelled by Kousso. This brought up the subject of tape worms and their elimination, which was ably discussed by several of the physicians. Dr. Snow thought that in forty-nine cases out of every fifty, the tape worm was produced by eating pork insufficiently cooked. Dr. Wigggin then read a paper on the "Treatment of Certain forms of Sterility," in which he detailed the facts of three cases coming under his observation, and bearing particularly upon this subject. It was an elaborate and scientific contribution, embodying much valuable information, and many facts wrought out by a careful and patient study of the cases above mentioned.

Dr. Whitney called attention to the possibility of typhoid fever occurring the second time in the same person, and suggested that the Society, for the benefit of the public if not for the members of the Society, investigate the matter, settling the question if it be a possible thing. Hero followed discussion upon typhoid fever, its causes, symptoms and general features being considered, Drs. Newhall, Gardner, Stanley and Garvin, each making a few remarks upon the different phases of the subject.

The following gentlemen were appointed by the President to read papers at the next meeting of the Society: Drs. C. W. Parsons, C. H. Fisher and A. G. Browning.

It was voted, on motion, that the next meeting of the Society be held in Providence. The meeting was quite well attended, and a deep interest manifested in all the proceedings. At 3.30, P.M., the Society adjourned.

Bibliographical Notices.

A Practical Treatise on Fractures and Dislocations. By FRANKE HASTINGS HAMILTON, A.M., M.D., LL.D., Professor of the Practice of Surgery in Bellevue Hospital Medical College, &c. Fourth Edition. Philadelphia: Henry C. Lea, 1871. Pp. 789.

We have once more before us Dr. Hamilton's admirable treatise, which we have always considered the most complete and reliable work on the subject. The book has already been fully reviewed in our columns. The new edition comes to us enlarged and enriched; some of the discussions and descriptions of old and now obsolete apparatus have been omitted, and their places filled by the suggestion of the latest views on fractures and dislocations. As a whole, the work is without an equal in the literature of the profession.

The Functions and Disorders of the Reproductive Organs, in Childhood, Youth, Adult Age and Advanced Life, considered in their Physiological, Social and Moral Relations. By WILLIAM ACTON, M.R.C.S., late Surgeon to the Islington Dispensary, &c. Third American, from the fifth London Edition. Philadelphia: Lindsay & Blakiston. 1871. Pp. 384.

The well-known work of Mr. Acton has reached a fifth edition, and, in this, has been thoroughly revised and partially rewritten. The book takes up the consideration of the normal and abnormal conditions of the generative organs and functions at the various stages of life, and treats them as they should be treated, in a thorough and scientific manner.

We are glad that the author takes occasion to handle without gloves all pseudomedical sensational works, the quacks who prey on the credulity of the community, and the cunningly wrought advertisements which are the curse of our secular and even the religious press. We wish that his wise words and excellent advice could be placed before the youth of our community who are misled by these harpies; that our statute books might contain laws which would punish them; and that our respectable journals would refuse to further their plans, by declining their obscene advertisements.

Headaches: their Causes and their Cure. By Henry G. Wight, M.D., M.R.C.S.L., L.S.A., &c. From the fourth London Edition. Philadelphia: Lindsay & Blakiston, 1871. Pp. 154.

An excellent little work, full of good thought, simple and practical in character.

Restorative Medicine. An Harveyian Annual Oration delivered at the Royal College of Physicians, London, by T. K. CHAMBERS, M.D., &c., with two Sequels. Philadelphia: H. C. Lea. 1871. Pp. 85.

This oration, delivered in June last, has been printed and published in America before its appearance in England. It is truly a pleasant conversational treatise on some of the phases presented by modern medicine; and is followed, still farther, by a brace of chapters of table talk, crisp and fresh, full of salient points and good hits.

"All rational cures," says our author, "seem to have resolved themselves into these five, namely: the Cures by Elimination, by Opposition of Contraries, by Assisting Nature, by Neutralization, by Counter-irritation. All except mere reactionary speculators have, till lately, followed the advances here implied. Examine each, and you will see that they are all agreed in one feeling as to the nature of disease, namely, that there is therein added to the animal frame something which needs to be reduced, or opposed, or assisted, or neutralized, or concentrated. Now it seems to me that the

medicine of to-day is to take an essentially opposite view. Daily stronger and stronger an impression is being borne in upon the practitioner's mind, as expressed in his acts, that disease is something less, not something more, than life. Under the light of advancing physiology, morbid substances and processes appear examples of arrested development, each one the more as the more intimate is our acquaintance with it. The end and aim of happy treatment is, therefore, essentially an addition, an endeavor to retain, to restore, to develop into fuller life those identical morbid substances and processes which have hitherto been uniformly condemned to expulsion." Thus he gives the key note to the thought which runs through his address, the consideration, in fact, of what true culture and development is, the *education*, which means a bringing out of powers, and not a stuffing of geese; which attains its object best when it sharpens the senses to rightly appreciate and take in facts for themselves, and burdens the memory as little as possible.

Medical and Surgical Journal.

BOSTON: THURSDAY, OCTOBER 12, 1871.

THE MASSACHUSETTS MEDICAL SOCIETY AND THE MEDICAL SCHOOL OF HARVARD UNIVERSITY.

We gladly announce the action taken by the Councillors at their meeting on Wednesday, October 4th, in reference to the radical changes instituted in the medical school, inasmuch as it shows the sentiment of the profession throughout the State, as expressed by their legal representatives. The resolutions, given below, were offered by Dr. Cotting, of Roxbury, and were seconded by Dr. Gage, of Worcester; the latter of whom, while expressing his personal gratification at the move, confidently stated it as his belief that the profession throughout the State would cordially support the University in its efforts to improve the methods of medical education. The resolutions were enthusiastically received, and passed unanimously.

"Resolved, That the Councillors of the Massachusetts Medical Society cordially welcome every wise attempt to raise the standard of medical education.

"Resolved, That, inasmuch as the Faculty of the Medical School of Harvard University, undeterred by difficulties, or risks of personal sacrifices, have adopted a scheme of medical instruction, which has been characterized as 'the boldest experiment ever tried in an American institution,' and which places this medical school far in advance of any similar institution in the country—we, as Councillors of the Massachusetts Medical Society, and individually as members of the medical profession, will heartily and assiduously (in the language of the President of the University) 'give the University the encouragement of our sympathy, the moral strength of our approbation, and the benefit of our advice to young men and their parents,' that, as far as in us lies, this eminently wise and long-hoped-for improvement in medical education may be fully sustained, and ultimately prove a conspicuous success.

"Resolved, That a copy of the foregoing resolutions, signed by the President and Secretary of this Society, be sent to the President of the University, to be communicated to the Faculty of the Medical School."

CUNDURANGO.

The following note has been received from Dr. Dole; it needs no explanation:—

"AMHERST, MASS., Oct. 7, 1871.

"MY DEAR DOCTOR.—The 'Case of Carcinoma treated with Cundurango,' published in your issue of September 28th, embraces my entire experience in the use of the drug. It affords, as you will perceive, no basis for an opinion as to its merits, but it adds something to the literature of a subject in which we are all interested, and may be of assistance to some one in the future. The publication of the data of the case in full will, at least, prevent unauthorized statements as to my experience. I remain,

Very truly yours, JOHN DOLE."

UNPAID SERVICE. *Dear Editor*.—I think that the admirable essay of Dr. Blanchard, in the JOURNAL of September 21st, must have struck medical men as being full of truth. Its subject, "Unpaid Medical Service," must have brought up to our minds the many charges upon our books, which

are destined ever to be such, unless the Millenium steps in or the public are brought to take a "new departure" in regard to the payment of physicians' fees.

It is high time that physicians waked up, and began to look about them to see if there cannot be some means taken to protect themselves. A certain class in all cities and towns drift from one doctor to another, without having the remotest idea of abstracting the smallest "piece of currency" from their worldly wealth to pay the physician for his labor; thinking, no doubt, that doctors can eat and drink and breathe in physic and so exist.

The only way to get at these leeches is for us to band ourselves together, as is done in some places, and keep a black list for circulation amongst ourselves. But it is said that this could not be done; that doctors would not "hang together," as it is expressed; and again that there are certain physicians who, for the sake of obtaining another physician's practice, would attend these patients whose names are sent round. If there are such, let them have all the patients of that class they desire. May they grow rich and wax fat from them. As to the other point, I think we can all drop—or at least ought to—our petty quarrels and hard feelings, and unite together in this matter for our common interest and prosperity.

A. B. C.

VERATRUM VIRIDE IN INFLAMMATORY AFFECTIONS. By J. LEWIS SMITH, M.D., Curator to the Nursery and Child's Hospital, New York.—In the treatment of inflammatory affections, Dr. Smith recommends the use of *aconite* or *veratrūm viride* as a substitute for bloodletting. The following paragraph refers to lobar pneumonia:—

"If the previous health of the patient has been good, his age above three years, the attack primary, and if the inflammation is, in part at least, in the first stage, aconite or vertrum viride, properly employed, is serviceable. Either one is an efficient substitute for bloodletting. Some prefer aconite as less depressing than veratrūm, and it is known to be a favorite remedy of homeopaths. I have ordinarily employed the veratrūm, prescribing the tincture in doses of one drop every three hours to a child of five years. It can be again dropped in sweetened water, or in syrup of tolu. Its effects should be carefully watched, and it should be omitted, or given less frequently, when the pulse is reduced to near the natural frequency.—*Treatise on the Diseases of Infancy and Childhood.*

BOSTON DISPENSARY.—The following are the statistics of this institution for the year ending Sept. 30th, 1871. The number of new patients at the Central Office is 17,704, of which 12,268 are medical cases, and 5436 surgical, classified as follows:—

	MEDICAL.			<i>Total.</i>
	<i>Men.</i>	<i>Women.</i>	<i>Children.</i>	
1st quarter,	585	1158	833	2576
2d "	837	1050	759	2646
3d "	778	1763	1112	3653
4th "	841	1398	1164	3303
Total,	3041	5369	3858	12,268

	SURGICAL.			<i>Total.</i>
	<i>Men.</i>	<i>Women.</i>	<i>Children.</i>	
1st quarter,	435	318	448	1201
2d "	525	370	450	1345
3d "	474	389	545	1408
4th "	479	479	524	1482
Total,	1913	1536	1967	5436

The number of new patients in the Districts is as follows:—

	MEDICAL.			<i>Total.</i>
	<i>Men.</i>	<i>Women.</i>	<i>Children.</i>	
1st quarter,	335	821	862	2038
2d "	528	1158	1002	2688
3d "	362	989	910	2291
4th "	379	910	892	2181
Total,	1654	3878	3366	9198

	RESULTS.			<i>Total.</i>
	<i>Discharged, cured or relieved.</i>	<i>Sent to Hospitals, or removed from Districts.</i>	<i>Died.</i>	
<i>Under treatment,</i>	—	—	—	123
<i>Under treatment at last annual report,</i>	—	—	—	9306
<i>Number of cases at Central Office,</i>	—	—	—	9,198
Total number at Central Office & in Districts,	26,902			

	PATIENTS, NEW AND OLD, AT CENTRAL OFFICE.			<i>Total.</i>
	<i>Medical.</i>	<i>Surgical.</i>	<i>Total.</i>	
1st quarter,	5167	1694	6861	
2d "	4832	1992	7824	
3d "	6331	1945	8476	
4th "	5934	2423	8357	
Total,	23,464	8054	31,518	

	RESULTS.			<i>Total.</i>
	<i>Number of cases of midwifery.</i>	<i>Number of receipts.</i>	<i>Number of receipts since July, 1856.</i>	
<i>Number of receipts.</i>	—	—	—	127
<i>Number of receipts since July, 1856.</i>	—	—	—	53,837
<i>Average daily attendance.</i>	—	—	—	102

	SURGEONS.			<i>Total.</i>
	<i>Francis H. Brown, M.D.</i>	<i>J. Brackett Treadwell, M.D.</i>	<i>Samuel W. Langmaid, M.D.</i>	
<i>Francis B. Greenough, M.D.</i>	—	—	—	
<i>Robert Dishrow, M.D.</i>	—	—	—	
<i>Wm. F. Munroe, M.D.</i>	—	—	—	
<i>Thos. Waterman, Jr. M.D.</i>	—	—	—	
<i>Charles E. Inches, M.D.</i>	—	—	—	
<i>Clarence J. Blake, M.D.</i>	—	—	—	

	PHYSICIANS.			<i>Total.</i>
	<i>J. McLean Hayward, M.D.</i>	<i>David F. Lincoln, M.D.</i>	<i>Henry H. A. Beach, M.D.</i>	
<i>Francis B. Greenough, M.D.</i>	—	—	—	
<i>Robert Dishrow, M.D.</i>	—	—	—	
<i>Wm. F. Munroe, M.D.</i>	—	—	—	
<i>Thos. Waterman, Jr. M.D.</i>	—	—	—	
<i>Charles E. Inches, M.D.</i>	—	—	—	
<i>Alfred L. Haskins, M.D.</i>	—	—	—	

	DISTRICT PHYSICIANS.			<i>Total.</i>
	<i>No. 1.—Charles P. Putnam, M.D.</i>	<i>No. 2.—John B. Fulton, M.D. (East Boston.)</i>	<i>No. 3.—Charles F. Folson, M.D.</i>	
<i>No. 4.—Wm. H. Hastings, M.D.</i>	—	—	—	
<i>No. 5.—Wm. L. Richardson, M.D.</i>	—	—	—	
<i>No. 6.—Reginald H. Fitz, M.D.</i>	—	—	—	
<i>No. 7.—Orlando W. Doe, M.D.</i>	—	—	—	
<i>No. 8.—Horace S. Everett, M.D. (South Boston.)</i>	—	—	—	

	Eugene A. Gilman, Apothecary; John H. Abbot, Assistant Apothecary; Henry C. Durkee, Second Assistant Apothecary.			<i>Total.</i>
	<i>SAMUEL A. GREEN, M.D., Superintendent.</i>	<i>—</i>	<i>—</i>	
	—	—	—	

A NEW SYRINGE FOR UTERINE INJECTION.
—At a meeting of the New York Obstetrical Society, Dr. B. F. DAWSON exhibited a new instrument for uterine injection. It consisted of a silver tube, which is enclosed by two steel blades or valves, which can be opened by pressure upon the handles of the instrument, thus dilating the uterine canal, allowing all fluid to escape which may be thrown in by the syringe attached to the extremity of the injector-tube. The opening and closing of the valves present the additional advantage of breaking up and removing any clots which may be in the uterine cavity, and collect so as to prevent reflux.

Dr. Noeggerath said he had used the instrument, and found it a good one. Where uterine catarrh has existed a long time, and the tissues are soft and readily dilatable, the instrument will be of service; but where the disease is recent, the tissues are too firm to allow of much stretching by such an instrument. The facility with which clots can be broken up and removed is a good feature in the instrument. It is not the entrance of the fluid nor the exit which sometimes occasions death; certain substances occasion death by reflex action resulting in an inflammation; the liquid goes to the depth of the utricular glands, which extend deep into the uterine tissue. The sesquichloride of iron, nitrate of silver and chloride of zinc have occasioned death.

Dr. J. C. Nott said he had also used Dr. Dawson's instrument, and thought it possessed many points of merit; he asked if there is danger in the injection of iron for hemorrhage when the uterus is dilated.

Dr. Noeggerath believed the subsulphate of iron less dangerous than the sesquichloride, from the use of which he once occasioned a metro-peritonitis.

Dr. J. G. Perry said he had seen flabby uteri contract vigorously on the injection of iodine. Dr. T. A. Emmet said he had seen such vigorous contraction as to eject the iodine which had been introduced.

Dr. E. R. Peaslee said that in metrorrhoea, metrorrhagia, or haemorrhage proper, the utricular glands are full, so that by injection he thought no fluid would pass into the glands; it is not necessary to have the injected fluid pass into the glands to get up sudden contraction, for the surface itself is very sensitive.—*Amer. Jour. of Obstetrics.*

FOREIGN BODY IN THE RECTUM.—The *Wien Medizinische Presse* for June 11th, 1871, contains the account of an interesting

case of retention of foreign body in the rectum.

A young man, 23 years old, complained of pain in the lower part of the bowels and pressure in the rectum. It was difficult to explore the abdomen by palpation and percussion on account of excessive tenderness; however, a circumscribed peritonitis was suspected. It was then learned that four weeks previously, in order to overcome a desire to go to stool, the patient had sat on the handle of his umbrella, which broke under the weight, and caused him to fall to the ground backwards, and since that time he had had pain in the abdomen, tenesmus and diarrhoea. An examination per anum with the finger revealed no foreign body, and no change in the mucous membrane of the rectum. After twelve days the peritonitis had so far diminished that a satisfactory examination could be made, and there was found a firmly resistent movable body near the outer edge of the right rectus abdominis near its lower end, which could not be reached per anum. Several enemas brought away mucous stools with masses of hardened feces. Some days later, by causing the patient to kneel in bed with the chest depressed, the right index finger was passed into the anus, and, by manipulating externally with the left hand, the foreign body could be felt by the index finger; it was found to be caught in the left side of the bowel. It was released, and then when the patient rose and kneeled uprightly, it followed the finger down until it could be seized with forceps and extracted. It proved to be the handle of an umbrella, four and a half inches long, with the cross part two and a half inches long. No injury to the bowels was caused by the extraction, and in a short time the patient recovered.

PROFESSOR HUXLEY ON MEDICAL EDUCATION.—First, with respect to the recipients of prizes, and to those who unsuccessfully compete for them. Whilst I heartily congratulate those who are successful in obtaining prizes, I still more heartily express the hope that those who do not attain success may continue in their efforts until they secure it. The successful men of this world are not those who go off at full gallop, but, if I may use racing phraseology, those who "stay." It often happens that those whose early career is slower and gentler than that of others, exhibit a greater amount of mind and tougher staying power, and come in at the winning post at last.

Prizes in schools of medicine are not to be spoken of lightly. They stimulate the energies of the student and give him a distinction at the commencement of the race, flattering to himself and promising future success. But the history of prizemen does not bear out the present theory. On the contrary, like precocious children, prize men too frequently break down in after life. We do not allude to him who is first in a single class, but to him who is first in all departments. As a rule, he is too heavily-weighted with honors to continue the long race of life which is before him. In fact, he has exhausted his energies before the real race of life has commenced. The career of too many successful prizemen affords a melancholy illustration of this fact. Broken down in constitution, their mental energies exhausted, they are nowhere, when the real struggle has to be made. I urge upon all the importance of plodding industry, which is often of more service than brilliancy or talent, and of using Pegasus as a plough-horse, instead of permitting him to soar aloft.—*Medical Times and Gaz.*

SASSAFRAS OIL.—The manufacture of sassafras oil has been conducted for the past two years in Richmond, Va., on an extensive scale. The oil manufactured amounts to two per cent. of the stock used, 800 pounds of unrectified oil being made from 40,000 pounds of the root. This quantity is further reduced by rectification and cleansing from sediment and impurity. A gallon of the fine oil weighs 10 pounds, and about 40 gallons are produced every week. The root is first cut up fine by a chopping machine, and the raw materials are placed in a large tub, which is closed, and steam is then forced through the mass. The oil is then distilled by the ordinary process. It is largely used for scenting toilet soap, and for flavoring tobacco.—*Med. and Surg. Rep.*

ICE IN THE RECTUM IN RETENTION OF URINE.—Dr. Cazenave says (*Jour. de Med. et de Chir.*) that during twenty years the following simple expedient has never failed in giving relief in retention of urine. He introduces into the rectum a piece of ice of the form of an elongated oval and about the size of a chestnut, which he pushes up beyond the sphincters, and renews every two hours. Almost always in an hour and a half, or two hours at longest, urethral spasm ceases, a certain quantity of urine is

passed, and the bladder is emptied without effort by the patient. If in rare and exceptional cases this does not take place, he introduces again pieces of ice into the rectum, and places broken ice from the anus up to the end of the penis, until the urine flows, which it infallibly does. When there is difficulty in making water, occasioned by prostatic hypertrophy, the good effects of the ice are rather longer coming on, but almost always are produced. In short, in these circumstances (strictures and prosthetic hypertrophies) the sedative effects are so well marked, thanks to the effects of the ice, that the introduction of bougies and sounds into the bladder and urethra is always rendered easy to practised surgeons, and hardly any pain is felt. In our Chronicle for May we mentioned Dr. Baillie's statement that ice per rectum was invaluable in the narcosis of chloroform. We have now to add that the same mode of using the same agent has been reported on for retention.—*The Doctor.*

MEDICINE IN RUSSIA.—According to the official reports for 1870, there were in that year 10,000 legally qualified medical practitioners in Russia; of whom 6113 held public appointments, and 4686 were engaged in private practice. There is about one medical man to each 7182 of the population. Among the lower classes, the value of rational professional assistance is quite unrecognized; and hence infectious diseases commit frightful ravages, and the mortality among children is greater than in any of the countries of western Europe.—*The Clinic.*

HOW TO COLLECT DIATOMS.—The *American Journal of Microscopy* recommends, as the best plan of collecting diatoms in large quantities, to tie a thin, fine piece of linen over the faucet of the hydrant in the evening, and allow a small stream of water to pass through it all night. In the morning take off the cloth and rinse it in a little water in a goblet. When ready to examine, take a drop of water from the bottom of the goblet with a small pipette, or glass rod, and place it on a flat side, or a slide with a concave depression, holding a few drops. Then, with a power of 100 or 350, sweep the field, and you will be rewarded with the sight of a wondrous collection of beautiful and unique forms.—*Ibid.*

THE Medical School of Strasburg will probably be removed to Nancy.

Medical Miscellany.

DR. TREULICH, OF MELWIK.—By reference to the *Wien Med. Presse*, for March 19, 1871, page 30, Dr. Busey, of Washington, will find that this Journal is right and the *American Practitioner* wrong in reference to the orthography of Dr. Treulich's name.

PROFESSOR MARSHALL'S scientific examination of the late Mr. Grote's head has revealed the fact that the brain was remarkably small; but it is said to have been rich in convolutions.

DR. F. J. BUMSTRAD, of New York, as he himself informs us, will sail for Europe on Saturday next, to spend a few months with his family abroad. He will return in the spring and resume practice at his former place of residence.

CHANGE OF CLIMATE AS A CURATIVE MEASURE FOR CONSUMPTION.—E. Holden, M.D., Newark, N. J. (*Am. Jour. Med. Sciences*), in his interesting paper on "Ostracism for Consumption," says that, after all, change of climate, invaluable and promising as it is as a curative measure for consumption, must yet fall far short of general applicability, since its successful prescription implies means, and means in abundance.

For a patient to leave home without near and dear friends would be madness, but without ample means it is suicide; and worldly and paradoxical as it may seem, there has been no truth more strongly forced upon him than that life, like every other blessing, is purchasable with money.—*N. Y. Med. Record*.

THE AMERICAN PHARMACEUTICAL ASSOCIATION.—The American Pharmaceutical Association which convened at the Polytechnic Institute in the city of St. Louis on the 11th ult., was perhaps the largest and most interesting meeting that has ever been held. Delegates from the various Colleges of Pharmacy in the United States were largely represented.

The convention was in session for four days, the time being devoted to the reading of scientific papers pertaining to the art of pharmacy. There was an exhibition of chemicals, pharmaceutical preparation apparatus, and in fact everything kept or used by the pharmacist, which was very much admired by every one.

The banquet given at the Southern Hotel, by the apothecaries of St. Louis, was a grand affair. It was presided over by Mr. James Richardson, and toasts were read and responded to by pharmacists of the various States.—*Leavenworth Med. Herald and Jour. of Pharmacy*.

THE Medical Record, in censuring surgeons for the contemptible method of using the daily Press for advertising themselves, uses the following satirical language: "Whatever may be said of the offenders in regard to their not being accessory to such acts of impropriety, it is a significant fact, that when threatened with expulsion from a Society, &c., unless some means are used to prevent further paragraphing, the notices do not appear. Perhaps from that time the ambitious individual ceases to make any more important discoveries or

to perform any more skilful operations.—*Richmond and Louisville Med. Jour.*

THE DARTMOUTH, N. H., MEDICAL COLLEGE meets with great loss in the retirement of Dr. Dixi Crosby, Dr. E. E. Phelps takes the chair of General Pathology, and Dr. E. P. Frost, of Brattleboro', Vt., that of the Theory and Practice of Medicine. The class numbers about forty.

E. W. Houghton, Esq., has given \$10,000 to Dartmouth Medical College, to establish a museum of Pathological Anatomy.—*Coll. Courant*.

SULPHOCARBOLEN OF ZINC IN OTORRHEA.—At a recent congress of German surgeons in Prague, Dr. Zaafal said that he had used solution of the sulphocarbolate of zinc in fourteen cases of otorrhœa, with satisfactory results. The strength of the solution was one or two grains to the ounce.—*Med. and Surg. Reporter*.

GENERAL AUSTRIAN APOTHECARIES' SOCIETY.—The annual meeting of this body, which was announced for Sept. 4th, was, on account of the election for the Legislature, postponed, and was held in the city of Linz, on Sept. 17th, 18th and 19th.—*Am. Jour. of Pharmacy*.

TO CORRESPONDENTS.—Communications accepted.—The Medical School of Wurzburg.

MARRIED.—In this city, on the 5th inst., Dr. Luther D. Shepherd to Miss Josephine Bailey, both of Boston.

Deaths in fifteen Cities and Towns of Massachusetts for the week ending Oct. 7, 1871.

Cities and Towns.	No. of Deaths.	Predominant Disease.
Boston	105	Consumption 31
Worcester	27	Typhoid fever 17
Lowell	24	Smallpox 15
Milford	1	Pneumonia 14
Salem	3	Dysentery & Diarrhea 12
Lawrence	9	Cholera infantum 12
Springfield	3	Croup 6
Lynn	12	Scarlet fever 6
Gloucester	4	
Fitchburg	3	
Taunton	7	
Newburyport	5	
Somerville	3	
Fall River	11	
Holyoke	2	
	219	

The deaths from smallpox were as follows: thirteen in Lowell, one in Boston, and one in Holyoke.

GEORGE DERNY, M.D.,
Secretary of State Board of Health.

DEATHS IN BOSTON for the week ending Saturday, Oct. 7th, 1871. Males, 51; females, 54. Accident, 7—inflammation of the bowels, 2—disease of the bowels, 2—bronchitis, 1—disease of the brain, 3—cancer of the liver, 1—cholera infantum, 6—consumption, 18—colic, 1—croup, 2—diarrhea, 3—dropsy, 1—dropsy of brain, 2—dysentery, 2—diphtheria, 1—epilepsy, 1—erysipelas, 1—scarlet fever, 1—typhoid fever, 7—intermittent fever, 1—gastritis, 1—disease of the heart, 6—infantile, 3—intermittent, 1—jaundice, 1—disease of the kidneys, 1—congestion of the lungs, 2—inflammation of the lungs, 8—miasma, 4—measles, 1—old age, 5—paralysis, 1—premature birth, 2—smallpox, 1—disease of the spine, 1—unknown, 4.

Under 5 years of age, 40—between 5 and 20 years, 12—between 20 and 40 years, 25—between 40 and 60 years, 13—above 60 years (including one aged 105), 15. Born in the United States, 75—Ireland, 21—other places, 9.